Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Prevention of Pack Palsy

TO THE EDITOR: This is to report a device that conceivably will reduce the incidence of pack palsy in backpackers. In the June issue Dr. Guy Corkill and associates[1] noted that pack palsy affects the upper trunk of the brachial plexus or the peripheral nerve supply to the shoulder girdle. It is caused by pressure from back straps.

A simple modification of the pack frame should be of interest to all physicians concerned with this problem. It is proposed to add to both sides of the bottom support of the frame a lateral horizontal forward extension appropriately shaped (Figure 1). Both arms, fashioned from aluminum tubing, cantilever forward past the side of the trunk. They provide a grip for both hands, and when the backpacker bears down on them they will tilt the top of the frame forward. This will relieve immediately the continuous pressure against the frontal shoulder area. Occasional lifting of the grip will modify the pressure to which the sensitive trapezio-scapular region is subjected.

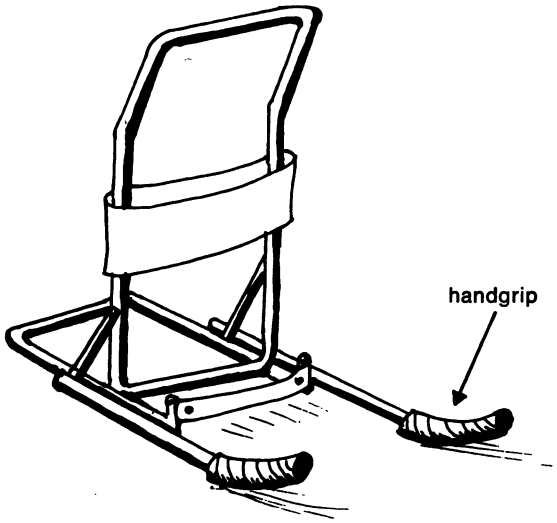

Figure 1.—View of the pack frame to which side extensions have been added. They permit shifting of the load on the shoulders. Straps have been omitted in the sketch.

During years of family backpacking trips I experimented with what I had called the Schmerl grip and have found it indispensable because it allows one to lighten the pack weight occasionally. During long hikes, I might add, it gives the dependent arms a chance of restful support and an intermittent active role. Subjectively, a pleasing sensation of relief in the upper extremities suggests, perhaps, hemodynamic variations due to such changes in pressure.

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REFERENCE

1. Corkill G, Lieberman JS, Taylor RG: Pack palsy in backpackers (Information). West J Med 132:569-572, Jun 1980

Treatment of Heat Stroke

TO THE EDITOR: Recently on the CBS Evening News, a heat-stroke victim was shown being given the recommended ice treatment[1] at a famous Dallas hospital affiliated with a distinguished medical school. The external application of ice is the wrong treatment for heat stroke. It aggravates the process it is meant to allay. By its vasoconstrictive effect on skin arterioles, it actually interferes with the normal process of heat loss through the skin, which the body in its superior physiological wisdom is trying to accomplish. However, it is gratifying to the physician to feel the iced body cool to his touch without disturbing him to inquire into the underlying physiology.

Evaporative cooling should be considered as a better alternative.[2] First, treat the life-threatening hypovolemic shock and the associated electrolyte deficiencies and imbalances; then lay the naked patient on a rubber or plastic sheet, wrap him in another of cotton continually doused with water and go about the careful examination of the patient for heart trouble, infection or other causes which may have made him more susceptible to the effects of heat. As circulation is restored the

cooled blood is returned to the internal organs with beneficial effect. Fans can be used to hasten the process of evaporation.

The patient given the ice treatment in Dallas died the following day.

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REFERENCES

1. Disturbances due to heat: Method of Edward A. Ernst, MD, *In* Conn HF (Ed): Current Therapy 1980. Philadelphia, WB Saunders, 1980, pp 918-919

2. Weiner JS, Khogali M: A physiological body-cooling unit for the treatment of heat stroke. Lancet 1:507-509, Mar 8, 1980

Commentary on Male Impotence

TO THE EDITOR: Recently, an article entitled "Impotence Is Not Always Psychogenic" by Spark, White and Connolly appeared in *The Journal of the American Medical Association.*[1] Considerable publicity was given this report in local newspapers (and, I presume, in the lay press nationally). Some of the implications that a lay or professional reader might glean from a cursory glance at the article impel me to write a brief constructive criticism, especially in view of some imperious demands for and assessment of serum testosterone level (and even some clinically questionable need for skull x-ray studies in search for a pituitary tumor) that have come to my attention since the above mentioned study was published.

As a result of my interest during the past 25 years in male psychogenic impotency, I have reported a technique of "urologic" counseling as treatment. To date, more than 300 men with impotency have been evaluated by me on a one-to-one basis. In our 1975 report of 62 such men, we found that more than 90 percent achieved satisfactory restoration of sexual function generally after three weekly sessions.[2] Our more recent report emphasized that, even in the presence of organic illnesses, including diabetes mellitus, or major vascular disease, and of operations such as radical prostatectomy, urologic counseling could aid in reinstatement of sexual function.[3] Thus far I have not assembled my data as to the exact percentage of successful recovery of sexual potency after urologic counseling.

In 1959 my colleagues and I defined sexual potency as "psychologic desire for coitus which produces penile erection adequate for intromission and climax."[4] Frequency of intercourse was specifically excluded from that definition. In the current paper by Spark and co-workers, who quoted Masters and Johnson's definition of impotence as greater than 25 percent erectile failures during attempted intercourse, six of seven men in their hypergonadotrophic-hypogonadism group were said to have engaged in successful intercourse "relatively infrequently" and ". . . episodes of failure caused major embarrassment." For purposes of uniformity, investigators should agree upon a definition and arrange case groupings without variations. Interjection of emotional factors ("embarrassment") clouds the issue. In addition, there is fundamental objection to combining *primary impotency* (never having had sexual experience) and *secondary impotency* in a single group.

Spark and his colleagues commendably reported that determining the serum testosterone level is a valuable step in the study of an impotent patient for the purpose of diagnosing ". . . a surprisingly high incidence of abnormalities of the hypothalamic-pituitary-gonadal axis." However, the conclusion that serum testosterone level may be diagnostically definitive must be challenged since it is well known that men with either normal or low serum testosterone level may be potent or impotent. Indeed a low testosterone level in an impotent man raises the question as to whether it precipitated the impotency or, on the contrary, was a consequence of sexual inactivity. Of the 105 patients in Spark's report, 68 had normal serum testosterone levels.

These authors found low testosterone levels in 37 men never previously evaluated by hormone studies. Among these patients many had significant endocrinopathies: 10 of 20 in the hypogonadotrophic-hypogonadism group had pituitary tumor. Physiologic effect of and subjective impact upon a man with pituitary tumor could well impair libido and potency per se, as would also apply to two other of their patients who had brain tumors and another who suffered pure red blood cell aplasia.

The presence of small or soft testes mentioned by Spark and his colleagues does not necessarily have clinical significance. Furthermore, castration has been performed in countless men with advanced prostatic cancer as a therapeutic step—and many of these men continued to perform sexually despite the debilitating effect of prostatic cancer.

With regard to diabetes mellitus, this writer is far more impressed with those 50 percent to 60